DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10101 (02/03) (Formerly DES 2034)

STATE OF WISCONSIN
WI Stats. S 49.47.(3)

WISCONSIN MEDICAID ELDERLY / BLIND / DISABLED APPLICATION AND REVIEW

Instructions: Before completing this form, read the attached instructions. Use black or blue ink only.

SECTION I – CLIENT INFORMATION

If you are completing this application/review for someone else the completed Medicaid Authorization of Representative Form (HCF 10126) must be attached. Information provided on this application should be about the applicant not the representative.

If this is a new application, do you need help paying for health care received during the past three months? ☐ Yes ☐ No	Check the language you want eligibility notices printed in. ☐ English ☐ Spanish	Language spoken at home.	Date Received (Office Use Only)	RFA Number (Office Use Only)

Name of Person Applying for Medicaid (Last, First, MI)	Telephone Number

Address (Street, City, State, Zip Code)

Mailing Address (only if different from where you live) (Street, City, State, Zip Code)

SECTION II - GENERAL INFORMATION

	Names (Last, First, MI) (You and, if married, your spouse.)	List names previously used. (Married, maiden or others used.)	Applying for Medicaid?	Race or Ethnic Code (Optional- see instructions)	Social Security Number (Applicants Only)	Gender
1-Applicant (1 – Is applicant in each section)			☐ Yes ☐ No			☐ Male ☐ Female
2– Spouse (2 – Is Spouse in each section)			☐ Yes ☐ No			☐ Male ☐ Female

SECTION II - GENERAL INFORMATION (cont.)

	Date of Birth (MM/DD/YY)	Marital Status Code (see instructions for codes)	Are you a U.S. Citizen? (Applicants Only)	Veteran?	Have you been determined blind or disabled by the Social Security Administration?	If you are disabled and not currently working, are you interested in working?	Have you received SSI in the past?
1			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III - EMPLOYMENT INCOME

(Continue list on another sheet of paper if more space is needed)

Are you and / or your spouse working? (list self-employment in Section IV, Self-employment Income) ☐ Yes ☐ No If yes, list details below. If no, go to section IV.

Name of Person Employed	Employer Name and Address	Date Employment Began	Gross Monthly Earnings Expected This Month (Before Taxes and Deductions)	Gross Monthly Earnings Expected Next Month (Before Taxes and Deductions)
			$	$
			$	$

SECTION IV - SELF-EMPLOYMENT INCOME

(Continue list on another sheet of paper if more space is needed)

Are you and / or your spouse self-employed? ☐ Yes ☐ No List net amounts reported to Internal Revenue Service (IRS) on tax forms.

Self-Employed Person	Business Name and Address	Type of Business	Net Annual Income	Depreciation Amount Claimed	Income you Expect to Earn this Year

SECTION V - UNEARNED INCOME

(Continue list on another sheet of paper if more space is needed)

Do you and / or your spouse have unearned income? ☐ Yes ☐ No If yes, list any unearned income below.

Name of Person Receiving Income	Type / Source (See instructions)	Gross Monthly Amount (Before Taxes and Deductions)	Name of Person Receiving Income	Type / Source (See instructions)	Gross Monthly Amount (Before Taxes and Deductions)
		$			$
		$			$
		$			$

SECTION VI – HOUSEHOLD EXPENSES

List household expenses (see instructions for examples of expenses). (Continue list on another sheet of paper if more space is needed)

Name of Person with Expense	Type of Expense	Amount	How Often Paid

SECTION VII – OUT-OF-POCKET MEDICAL EXPENSES

Describe the Medical Expense	Indicate if the Medical Service / Item is a Work or Non-Work Expense	Amount	How often paid? (Monthly, Bimonthly, Weekly)
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	

SECTION VIII – ASSETS

List all assets owned by the applicant(s). Include assets owned jointly. Do not include the value of personal household belongings, unless of unusually high value, or motor vehicles. Continue list on another sheet of paper if more space is needed.

	Name of Owner(s)	Current Dollar Value	Description (Bank / Financial Institution Name, and Account Number)	Name of Owner(s)	Current Dollar Value	Description (Bank / Financial Institution Name, and Account Number)
Cash		$			$	
Checking Account		$			$	
Savings Account		$			$	
Real Estate / Property		$			$	
Burial Assets / Burial Insurance		$			$	
Life Insurance		$			$	
Other (list type)		$			$	
Other (list type)		$			$	
Other (list type)		$			$	

SECTION IX - VEHICLE INFORMATION

List all vehicles owned by applicant(s). Include vehicles owned jointly with another person. Continue list on another sheet of paper if more space is needed.

Type of Vehicle	Year, Make and Model of the Vehicle	Name of the Owner(s)	Amount owed? (If nothing is owed, list "0")	Vehicle used to get to medical appointments?	Is vehicle used for employment, training, school, or farming?
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No

SECTION X – MEDICAL INSURANCE INFORMATION

	Do you and/or your spouse have medical insurance coverage (other than Medicaid)?	Date Coverage Began (mm/dd/yy)	Premium Amount	Premium paid? (Quarterly, Monthly, Bimonthly, etc.)	Who pays the premium?	Policyholder Name	Who is covered?	Insurance Company Name and Address	Insurance Number (may include member, subscriber, division, group number)
1	☐ Yes ☐ No		$						
2	☐ Yes ☐ No		$						

MEDICAL INSURANCE INFORMATION CONT.

	Are you and/or your spouse covered by the Wisconsin Health Insurance Risk Sharing Program (HIRSP)?	Have you and/or your spouse incurred medical bills as a result of an accident or do either of you have an accident claim or settlement pending? ☐ Yes ☐ No If yes, check if you and/or your spouse have incurred bills or have a claim or settlement pending.	Are you and/or your spouse receiving Medicare Part A or B?	Medicare Card Number (If you and/or your spouse receive Medicare, list your card Medicare card number.)	If eligible, would you and/or your spouse like the State of Wisconsin to pay your Part B premium?
1	☐ Yes ☐ No	☐ Incurred bills ☐ Claim or Settlement Pending	☐ Yes ☐ No		☐ Yes ☐ No
2	☐ Yes ☐ No	☐ Incurred bills ☐ Claim or Settlement Pending	☐ Yes ☐ No		☐ Yes ☐ No

SECTION XI - RESOURCE TRANSFER

A worker may be contacting you for more information if needed. (Continue list on another sheet of paper if more space is needed)

	Have resources or assets been given away within the last three years? ☐ Yes ☐ No If yes, list type of resource or asset, the value, and the date it was sold or given away.				Has you and/or your spouse set up or funded a trust in the last five years?	Do you want your spouse to keep the maximum allowed portion of your income if you are institutionalized? ☐ Yes ☐ No If No, how much will be made available.
1	Type of Resource/Asset		Type of Resource/Asset:		☐ Yes ☐ No Type	$
	(MM/DD/YY)	$	(MM/DD/YY)	$	(MM/DD/YY)	
2	Type of Resource/Asset		Type of Resource/Asset		☐ Yes ☐ No Type	$
	(MM/DD/YY)	$	(MM/DD/YY)	$	(MM/DD/YY)	

List the following information if you and/or your spouse is in a nursing home or hospital.

	Name of Person in Nursing Home or Hospital	Name of Nursing Home or Hospital	Date of Admission to each Nursing Home or Hospital
1			
2			

SECTION XII - Rights and Responsibilities

Please read the Rights and Responsibilities, Section XII on the instructions before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of each household member, applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The applicant's signature must be witnessed by two people if signed with an "x".)

SIGNATURE – Applicant / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Spouse / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness (Needed if Application Signed with an "X" above)	Date Signed
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